IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

**CERTIFIED MAIL: 7005 1160 0000 1506 9469**

August 21, 2008

Joseph S. Bleymaier, Administrator
Emmett Rehabilitation & Healthcare
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bleymaier:

On **August 7, 2008**, a Complaint Investigation survey was conducted at Emmett Rehabilitation & Healthcare, Inc by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be an **ISOLATED** deficiency that constituted immediate jeopardy to resident health and safety. You were informed of the immediate jeopardy situation in writing on **August 7, 2008**.

On **August 7, 2008**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. However, the deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when

each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 3, 2008**. Failure to submit an acceptable PoC by **September 3, 2008**, may result in the imposition of additional civil monetary penalties by **September 23, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy **F314 -- S/S: J -- 42 CFR §483.25(c) -- Pressure Sores** cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

> **Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**
>
> A 'per instance' civil money penalty of **$5000.00**.
> (*THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510*) (§488.430)

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &**

**Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 7, 2009**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

**F314 -- S/S: J -- 42 CFR §483.25(c) -- Pressure Sores**

has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Resident # **1** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **September 3, 2008**. If your request for informal dispute resolution is received after **September 3, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

**STATE ACTIONS** effective with the date of this letter (**August 21 2008**):

Due to the serious nature of the deficiencies at **C789, IDAPA 16.03.02.200.03.b.v.**, the Department is placing the facility on a **Provisional License**. Enclosed is Skilled Nursing Facility License #**19**. This license is effective through **February 21, 2009**. The conditions of the Provisional License are as follows:

1. Correction of the licensure deficiencies, especially **C789**.

2. The facility must obtain weekly consultation from a qualified professional who is not an employee of the facility. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, and corrective actions taken, and the current status of each deficient area. The consultant can be an employee of the corporation.

3. Before we conduct a revisit, the consultant must attest that the facility is in substantial compliance with all requirements.

**Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license.** *IDAPA 16.03.02.003.05.a.* states:

a. Additional causes for denial of a license may include the following:

I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at *IDAPA 16.05.03.300*. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (*IDAPA 16.05.03.301*).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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August 26, 2008

Joseph S. Bleymaier, Administrator
Emmett Rehabilitation & Healthcare, Inc.
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bleymaier:

On **August 7, 2008**, a Complaint Investigation and State Licensure was conducted at Emmett Rehabilitation & Healthcare, Inc. David Scott, R.N., Amanda Bain, R.N. and Kari Davies, R.D. conducted the complaint investigation. A total of 30 hours were required to complete this complaint investigation.

The investigation team reviewed the following documents:

- The identified resident's record as well as three additional residents' records identified with pressure ulcers,
- the facility's Pressure Ulcer Prevention protocol,
- in-services regarding skin/wound care since January 2008,
- Resident Council minutes for the previous six months,
- grievances for the previous six months, and
- staffing records for the previous three weeks.

The investigation team interviewed the following staff members:

- The administrator,
- Director of Nursing,
- two owners,
- Corporate Vice President,
- one Registered Nurse,

- two Licensed Practical Nurses,
- a Physical Therapy staff member,
- a maintenance worker, and
- the Dietary Manager.

The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00003709**

ALLEGATION #1:

The complainant stated an identified resident entered the facility with no skin breakdown. About three months ago, the resident developed a very small pressure ulcer to the buttocks. The complainant stated that the facility did "some treatments," however, the pressure ulcer has now become very large and the facility did not alter skin treatments when it became apparent the wound was getting worse. The resident has frequent complaints of pain. The complainant states other residents in the facility also have developed skin breakdown due to neglect by the facility, but was unable to provide any additional names. The complainant was unsure if the resident's family is aware of the pressure ulcer.

FINDINGS:

The citation at F314 is for the facility's failure to provide the services necessary to prevent the identified resident from developing an avoidable pressure ulcer. In addition, the facility failed to accurately and consistently evaluate the identified resident's risk for skin breakdown and, once a pressure ulcer developed, monitor and document interventions. Weekly skin assessment records, including measurements and descriptions of the wound and surrounding tissue, were incomplete and, at times, inaccurate as to the condition of the right pressure ulcer. In addition, consistent documentation of treatments, antibiotics and nursing skin checks did not occur. Timely updates to the resident's care plan did not take place when the pressure ulcer first developed to reflect the change in condition and ordered interventions. Lab results in the resident's record revealed the presence of Methillin resistant staphylococcus aureus and Escherichia coli infections. The record did not document implementation of contact precautions to prevent the spread of infection to other residents, family or staff. At the time of the complaint investigation on August 6, 2008, the planned intervention for the wound was an appointment scheduled for August 13, 2008, at a wound clinic.

The citation at F272 is for the facility's failure to accurately and consistently assess and document the identified resident's skin integrity and wound. The citation at F278 is for the facility's failure to code the identified resident's MDS correctly to indicate the presence of a pressure ulcer. The citation F280 is for the facility's failure to revise the identified resident's care plan for a change in skin status and to include new interventions. The citation at F385 is for the facility's failure of the physician to ensure adequate supervision of the medical care of the identified resident's pressure ulcer. Finally, the citation at F441 is

for the facility's failure to ensure infection control practices met professional standards of care.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135020 | A. BUILDING _____ B. WING _____ | C 08/07/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMMETT REHAB & HEALTHCARE INC | 714 NORTH BUTTE AVENUE EMMETT, ID 83617 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during a complaint investigation at your facility.<br><br>The surveyors conducting the survey were:<br><br>David Scott, RN<br>Amanda Bain, RN<br>Kari Davies, MPH, RD, LD | F 000 | This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Emmett Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. | |
| F 272 SS=D | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the | F 272 | F 272<br><br>1. Resident #1 has been thoroughly re-assessed. The Skin at Risk (Braden Scale) form has been reviewed and up-dated. A head to toe skin assessment has been done on a weekly basis to identify any new issues as well as moniter progress of any previous issues. Weekly measurements have been documented for this wound. The careplan has been reviewed and revised to reflect risk factors, goals and interventions. The attending physician, as well as the physician and staff at the Center for Wound Healing at St. Luke's Meridian have also assessed her and contributed to the current treatment for her wound. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] ADMINISTRATOR 9/6/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
SEP 17 2008
FACILITY STANDARDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 272 | Continued From page 1<br>resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to accurately assess and document skin care issues related to pressure ulcer development and monitoring. This was true for 1 of 4 (#1) sampled residents and had the potential to affect any resident with actual or potential skin impairment. The findings include:<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses including multiple sclerosis, depressive disorder and kidney calculus.<br><br>A Weekly Skin Check form for April 2008 included an entry dated 4/2/08, which stated, "No new skin issues at this time."An entry for 4/9/08 stated, "Open area noted to gluteal fold on R [right]. Cream applied." An entry for 4/16/08 stated, "Cont[inue] to have sm [small] open area on R Glut[eal] fold. Protective cream applied. Will cont[inue] to monitor." No measurements or other entries were made for April 2008.<br><br>A Weekly Skin Check form for May 2008 had entries for 5/4, 5/15, and 5/21. The entry for 5/4 stated, "Peri area. Cocyx (sic) cracked, cream applied." The entry for 5/15 stated, "No new issues, peri area better." No mention was made of the open area to the gluteal fold. The entry for 5/21 stated, "No new issues noted." Again, no mention was made of the open area to the gluteal fold. No entry was made for the last week in May. | F 272 | F 272 (Continued from page 1)<br><br>2. All residents in the facility could be affected by the deficient practice. All current residents have been assessed for skin concerns. All Skin at Risk (Braden Scale) forms have been reviewed and revised as needed. A weekly head to toe skin assessment has been assigned to specific nurses for completion. Other residents noted to have pressure areas have had weekly wound measurements recorded. Care-plans for each resident have been reviewed to ensure that risk factors, goals, and interventions related to prevention of pressure sores are accurate.<br><br>3. Licensed Nurses have been instructed in the use of the weekly skin assessment form and the Braden Scale. Nurses have been involved in auditing the Braden Scales and careplans to ensure that risk factors are addressed and interventions are appropriate. CNA staff have been inserviced related to observing and reporting skin concerns to their nurse. CNA staff have been involved in auditing their own documentation and communication related to skin concerns. Facility nurses will be assigned to do weekly skin assessments on an on-going basis. | |

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| F 272 | Continued From page 2<br>A Weekly Skin Check form for June 2008 had entries for 6/5, 6/11, 6/20, and 6/24/08. The entry for 6/5/08 stated, "R buttock fold open area, cleansed. Skin is peeling on L[eft] Buttock. No other skin issues at this time. Will cont to monitor." The entry for 6/11 stated, "R buttock open area. Cleansed and new drsg [dressing] applied." The entry for 6/20 stated, "No new skin issues to report." The entry for 6/24/08 stated, "Res[ident] has an open red area on L buttock fold area, cleansed well. Will cont to monitor." The notation of an open area on the Left buttock appeared to be in error as the only other documented open area was to the Right gluteal fold.<br><br>The lack of complete documentation of skin checks and consistent wound monitoring was brought to the facility's attention on 8/6/08 at 11:40 AM. No further information or documentation was provided. | F 272 | F 272 (Continued from page 2)<br><br>4. Weekly skin assessments have been assigned to specific nurses. Compliance with completion of skin assessments is being monitored by the DON, Corp. RN, or assigned RN. This program is now a facility practice. Nurses who do not comply with assessment expectations will be subject to the progressive disciplinary process. One licensed nurse has been terminated, following multiple progressive disciplinary sessions related to documentation concerns, as well as the lack of willingness to communicate concerns related to changes in resident status to appropriate facility personnel. Her lack of follow through contributed to the progression and deterioration of this wound. Weekly measurements of pressures sores will be completed and documented by the DON or designee. Monthly reports will be presented to the Quality Assurance (QA) Committee by the DON.<br><br>5. Completion date: 9/05/08. | |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | F 278<br><br>1. Resident #1's wound originated as an abrasion caused by the mechanical lift sling. It was coded as an abrasion. Resident #1 has been reassessed by the MDS Coordinator, the DON and the IDT. | |

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| F 278 | Continued From page 3<br>false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, it was determined that 1 of 4 sampled residents had an incorrectly coded MDS assessment for pressure ulcers. This had the potential to affect all residents either admitted with, or who later developed a pressure ulcer. The findings include:<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses including multiple sclerosis, depressive disorder and kidney calculus.<br><br>Resident #1's record documented the development of a pressure ulcer to the right gluteal fold beginning on 4/13/08. The pressure ulcer deteriorated to a stage IV by the time of the survey on 8/6/08.<br><br>Resident #1's annual MDS assessment, dated 6/10/08, documented that the resident had bruises or abrasions but did not have any pressure ulcers.<br><br>The inaccurately coded MDS assessment was | F 278 | F 278 (Continued from page 3)<br><br>Her MDS has been coded to accurately reflect her current status.<br><br>2. All residents with skin concerns could be affected by the deficient practice. Based upon findings from weekly skin assessments, the MDS Coordinator has reviewed and revised all MDSs to ensure that current wounds are coded appropriately.<br><br>3. The facility MDS Coordinator will be completing the AANAC on-line MDS Certification Course. This will enable her to have access to current Q and A's from a nationally accredited organization, as well as have the support of peers in the RAI Assessment arena for unusual coding questions/answers. The DON and MDS Coordinator will review the Weekly Skin Assessment forms to ensure that any new areas of concern are identified and coded per the RAI manual. All existing wounds will be monitored to ensure that changes in wound status are reflected on MDS Assessments, as needed.<br><br>4. MDS coding will be monitored monthly through the QA Committee. The Quality Indicator reports, as well as the monthly skin/wound reports will be | |

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| F 278 | Continued From page 4<br>brought to the facility's attention on 8/7/08 at 11:30 am. No further information or documentation was provided. | F 278 | F 278 (Continued from page 4)<br><br>reviewed to determine if coding errors have been made. Errors noted will be re-evaluated using the RAI manual and support network to determine appropriate coding strategies.<br><br>5. Completion date: 9/5/08. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to review and update care plans for new pressure ulcer development and skin treatments. This was true for 1 of 4 sampled residents (#1) and had the potential to affect all residents with a change in skin integrity or treatments. The findings include:<br><br>Resident #1 was admitted to the facility on | F 280 | F 280<br><br>Of note, upon change of ownership of the facility in October of 2007, the computerized careplans for each resident were re-entered into the database. Dates for specific intervention updates were not individually keyed in, but rather folded into the baseline careplan for each resident. The 2567 indicates that the careplan was not updated since 2005. This is not an accurate statement.<br><br>1. The careplan for Resident #1 has been reviewed and revised to reflect her current status.<br><br>2. All residents could be affected by the deficient practice. Careplan updates from here forward will have dated revision input to reflect ongoing changes to the working careplan. Specific careplan changes related to Pressure Sores and/or preventative measures | |

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| F 280 | Continued From page 5<br>10/1/05 with diagnoses including multiple sclerosis [MS], depressive disorder and kidney calculus.<br><br>Resident #1's initial care plan for "Skin Integrity Impaired", dated 10/14/05, listed the problem of, "Rash, fragile coccyx, increase tone feet, ankles with pot[ential] for breakdown." The listed goal was, "Skin will be intact", and the listed approaches were:<br>* "Treatment per physician's order,<br>* Spenco overlay,<br>* Turn and reposition per policy,<br>* Skin checks per facility policy,<br>* Encourage resident to comply with cares, hydration and nutrition,<br>* Examine skin with cares. Notify LN of any red/open areas."<br><br>A Care Plan Update, dated 10/14/05, documented the problem of, "Potential for injury, infection, skin breakdown r/t [related to] Dx [diagnosis] MS, UTI [urinary tract infection], immobility, and resistance to cares." The listed approach was, "Place duoderm over areas Q wk [every week] and PRN [as needed], turning schedule Q 2 hours [every 2 hours] and PRN, encourage resident to comply with cares and hydration/nutrition."<br><br>A Weekly Skin Check form, dated 4/9/08, stated, "Open area noted to gluteal fold on R[ight]. Cream applied."<br><br>A Physician's Order was received on 4/12/08 to, "Apply EPC cream to R gluteal fold. CNA may apply, LN to asses Q day."<br><br>The care plan for Resident #1 was not updated in | F 280 | F 280 (Continued from page 5)<br><br>have been reviewed and revised to reflect current status for all residents.<br><br>3. The Licensed Nurses and the IDT have been inserviced about the importance of updating careplans when resident needs change or new orders are received. The Medical Records department manager, the MDS Coordinator and the IDT have been inserviced about updating careplans to reflect the ongoing efforts of the facility to evaluate careplan effectiveness and reflect the revisions made. The IDT reviews and revises careplans on a Quarterly basis. Careplans entered into the computerized database will reflect the dates that new interventions were added to the careplan. Temporary interventions (such as wound treatments or short interval monitoring) will not be incorporated into the comprehensive careplan, but rather maintained on the Temporary Careplan sheet in front of the comprehensive careplan. During the quarterly careplan review, any temporary issue that has not been resolved will be reviewed for consideration of addition to the comprehensive plan of care. This process is the responsibility of the MDS Coordinator and the assigned nurse who prepares the monthly updates for MAR | |

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| F 280 | Continued From page 6<br>April, May, or June 2008 to reflect neither the change in skin integrity or the new interventions.<br><br>A physician's order, dated 7/1/08, directed staff to, "Culture/swab wound to [right lower] buttock crease" and report the results of that laboratory test to the physician. That order was confirmed in an Interdisciplinary Progress Note (IDT Note) on 7/1/08 that read, "Received telephone call from [physician] regarding well being of resident. This nurse reported findings from this AM [morning] dressing [change] to [right] buttock. N.O. [New order] received for wound swab of area to be sent for culture."<br><br>A Care Plan Update, dated 7/1/08, identified the following Problem: "Res[ident] has an area to her [right] buttock crease. Possible infection. Approx[innately] 2.5 cm [centimeters] circular in the center of a known denuded area." The identified Goal documented, "Treat any underlying infection identified from wound swab." The Care Plan Update documented the following Approach: "1. Obtain wound swab as [ordered] 2. Review results [with physician] when available 3. Monitor for pain 4. Monitor for s/s [signs and symptoms] of infection, fever, etc. 5. Reassure resident as necessary."<br><br>A physician's order, dated 7/11/08, documented, "Wound care: Rx [Prescription] per wound protocol Idodosorb: to center area [and] cover with COPA hydrophilic foam dressing. [Change] dressing [every] 2-3 days and PRN. Apply [with] small amount gauze."<br><br>A Care Plan Update for Resident #1, dated 7/11/08, documented the following Problem: "Wound to [right] buttock crease. Change to | F 280 | F 208 (Continued from page 6)<br><br>(Medication Administration Accord)/TAR (Treatment Administration Accord) and flow sheets.<br><br>4. Careplans will be monitored by the IDT. Reports related to compliance with Careplan updates will be presented by the MDS Coordinator to the QA Committee on a monthly basis for the next 3 months, then Quarterly.<br><br>5. Completion date: 9/5/08. | |

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| F 280 | Continued From page 7<br>dressing. Per facility protocol." The identified Goal documented, "Heal area to buttock. Reduce the risk of any further breakdown. Maintain skin integrity." The Care Plan Update documented the following Approaches: "1. Apply dressing as protocol. Measure [every] week. 2. Monitor and record dressing [every] day and PRN. 3. [Change] dressing [every] 2-3 days and PRN. 4. Assess for pain [every] shift and PRN. 5. Skin [checks every] week and PRN."<br><br>The facility's Pressure Ulcer Prevention protocol states, "Periodic evaluation of the careplan and effectiveness of interventions will be completed. Revisions will be made as indicated."<br><br>The facility was made aware of the lack of prompt evaluation and revision of Resident #1's care plan on 8/6/08 at 11:20 am. No further information or documentation was provided.<br><br>Resident #1's initial care plan for skin integrity, dated 10/14/05, was not updated until 7/1/08 despite documentation identifying a change in skin condition and new treatments starting on 4/9/08. | F 280 | | |
| F 314 SS=J | 483.25(c) PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | F 314 | F 314<br><br>1. Resident #1 has been thoroughly assessed. The Skin at Risk Assessment has been updated. She has had a head to toe skin check completed on a weekly basis. Her wound has been assessed by her physician, as well as the physicians and staff at the Center for Wound Healing at the Meridian St. Luke's Regional Medical Center. Weekly wound measurements have been | |

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| F 314 | Continued From page 8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, record review, and a complaint from the general public, it was determined the facility failed to prevent, treat, and monitor pressure ulcers for one of four [#1] sampled residents. This resulted in serious injury which constituted an Immediate Jeopardy to Resident #1, who developed a preventable stage IV pressure ulcer. The failure of the facility to appropriately assess, treat, and monitor skin care issues had the potential to affect all residents with, or at risk for, pressure ulcers.<br><br>This situation was brought to the attention of the facility on 8/7/08 at 1:15 pm, at which time the facility was provided with specific details of the failure to prevent a pressure ulcer.<br><br>The facility provided an acceptable plan of correction to the surveyors on 8/7/08 at 2:20 pm, at which time the Immediate Jeopardy was abated. The plan of correction is as follows:<br><br>1. Resident #1's Physician came into the building on 8/7/08 to examine and debride the right buttock wound. The facility's staff would send the physician weekly measurements and wound assessments.<br>2. An appointment at a wound clinic was scheduled for August 13.<br>3. New dressing change ordered.<br>4. Resident #1 was placed in contact isolation.<br>5. A new air bed and pressure relief cushion were ordered for Resident #1.<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses including multiple sclerosis, depressive disorder, and calculus of the | F 314 | F 314 (Continued from page 8)<br><br>recorded by licensed nurses. Daily wound observation has been documented and a weekly wound progress report has been forwarded to the attending physician. Medastat delivered a new air bed and air cushion for her wheel chair. Staff were inserviced on the appropriate use of this equipment. The Medastat representative personally checked the pressure gauges on her bed on two separate occasions since survey. Pressure readings for this bed are being monitored by the licensed nurses on a daily basis. The Registered Dietician has reviewed the resident's plan of care and has made appropriate recommendations. The resident will be reviewed weekly in the Nutrition at Risk Committee meeting. The Consultant Pharmacist completed a review of the resident's chart. Recommendations have been forwarded to her physician. Licensed staff and CNA staff working with Resident #1 have participated in a review and revision of her careplan. Resident went to the Wound Clinic on August 26th and now has a wound vac in place. The respresentative from KCI (rental company for wound vac) visited facility and provided training related to use of the wound vac equipment by staff. The representative from Smith | |

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| F 314 | Continued From page 9<br>kidney.<br><br>Resident #1's admission MDS, dated 10/7/05, coded a stage III pressure ulcer.<br><br>A Skin Integrity Impairment form for Resident #1, dated 10/1/05, identified the problem of "Skin integrity impaired...Sacrum breakdown, stage 3 noted on admit." The listed interventions included:<br>*Air mattress,<br>*Pressure reduction cushion to bedside chair and/or wheelchair/geri chair,<br>*Follow in wound team rounds, ensure pain management program is effective,<br>*Use turn sheet for repositioning,<br>*Daily skin inspection during cares. Notify LN of skin integrity impairments,<br>*Weekly licensed nurse skin assessment, and<br>*Weekly check for "bottoming out" in w/c [wheelchair] and/or bed.<br><br>A Weekly Pressure Ulcer Condition Report, with dated entries of 10/2/05 and 10/9/05, documented Resident #1's sacral wound. The entry for 10/2/05 stated the wound was a stage III with a distinct outline, absence of necrotic tissue, a scant amount of serosanguineous exudate, and minimal edema of the surrounding tissues. The treatment was "DuoDerm placed for protection." The entry for 10/9/05 stated the wound was "now closed" and the DuoDerm was discontinued.<br><br>Resident #1's initial care plan, dated 10/14/05, listed the problem of "Skin integrity impaired." The approaches listed were:<br>*Turn and reposition per policy,<br>*Skin checks per facility policy,<br>*Examine skin with cares. Notify LN of any red/open areas. | F 314 | F 314 (Continued from page 9)<br><br>and Nephew visited the facility and provided 1:1 inservice training for the (now former) DON. The COTA and Physical Therapist reviewed the seating system for Resident #1 with the representative from Medastat to ensure appropriate pressure relief, and that position needs were met. (Resident is currently on bed rest and uses wheel chair only for transport to appointments. She will be re-evaluated once the wound is healed and resident is allowed to resume wheel chair seating.)<br><br>2. All residents could be affected by the deficient practices noted in this survey. The skin/wound program has been reviewed with all licensed staff as well as CNAs. Licensed staff and CNAs have been involved in auditing charts to identify documentation concerns (this has been done to educate staff about how they may have contributed to the breakdown in this system). All Resident Skin at Risk Assessments have been reviewed. Careplans have been reviewed and/or revised to ensure that all risk factors, goals and interventions related to pressure ulcer prevention and treatment are accurate. All LNs have been assigned specific residents for weekly skin checks. Results of weekly skin checks are being reviewed by the | |

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| F 314 | Continued From page 10<br><br>A care plan update, dated 10/14/05 clarified, "Place DuoDerm over areas Q wk and PRN [every week and as needed], turning schedule Q2 hours and PRN, encourage resident to comply with cares and hydration/nutrition."<br><br>The initial care plan, dated 10/14/05, was not updated to include changes in skin integrity until 07/01/08.<br><br>The initial Pressure Ulcer Risk Assessment Tool for Resident #1, dated 1/5/06, scored the resident at a high risk for skin breakdown due to: history of healed pressure ulcer, pain, H/O MS [history of multiple sclerosis].<br><br>The Pressure Ulcer Risk Assessments, dated 2/9/07 and 3/17/08, scored the resident as a low risk for skin breakdown despite having a history of pressure ulcers, being bed and chair bound, totally reliant on staff for ADL's and repositioning, indwelling catheter, and previously been scored as a high risk on the same assessment tool.<br><br>A Weekly Skin Check form for February 2008 had entries for 2/3, 2/9, 2/17, and 2/23/08. Each entry stated the resident's skin integrity was intact and there were no new skin issues.<br><br>A Weekly Skin Check form for April 2008 included an entry dated 4/2/08, which stated, "No new skin issues at this time."An entry for 4/9/08 stated, "Open area noted to gluteal fold on R [right]. Cream applied." An entry for 4/16/08 stated, "Cont to have sm [small] open area on R Glut[eal] fold. Protective cream applied. Will cont[inue] to monitor." No measurements or other entries were made for April 2008. | F 314 | F314 (Continued from page 10)<br><br>DON and Corporate Nurse Consultant. Education related to accuracy of assessments, and implementation of the full wound care program is being done on an individual basis, as needed. (This education includes assessment of skin issues, notification of physician, implementation of wound care protocol, setting up appropriate documentation cues for staff, notification of dietary and therapy departments, updating careplans, follow up assessment and documentation.) CNA documentation is being reviewed as well. Specific staff requiring more education have been identified and education is ongoing. Wound measurements are maintained on a weekly basis. Wound progress reports are being sent to the attending physicians for resident affected. A facility wide audit of seating systems, beds/mattresses, shoes, as well as other preventative measures has been completed. Results of audit have been shared with appropriate personnel and corrective actions have been implemented to resolve findings.<br><br>3. Systemic changes implemented to ensure that this deficiency does not continue to occur include:<br>• Licensed Nurse and CNA inservices | |

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| F 314 | Continued From page 11<br><br>A Documentation Record Comments form, dated 4/13/08, stated, "After shower LN did a skin check on resident and we found her bottom was open and slightly bleeding."<br><br>A physician's order was received on 4/12/08 to "Apply EPC cream to R gluteal fold. CNA may apply, LN to assess Q [every] day." The MAR revealed no documentation that the cream was applied on 4/3, 5, 10, 16, or 23. In addition, no documentation was found to indicate the LN did daily wound assessment on 4/16, 17, 18, 19, and 22 through the end of the month.<br><br>The April 2008 care plan for Resident #1 was not updated to reflect the new skin issues or the interventions to be implemented.<br><br>A Weekly Skin Check form for May 2008 had entries for 5/4, 5/15, and 5/21. The entry for 5/4 stated, "Peri area. Cocyx [sic] cracked, cream applied." The entry for 5/15 stated, "No new issues, peri area better." No mention was made of the open area to the gluteal fold. The entry for 5/21 stated, "No new issues noted." Again, no mention was made of the open area to the gluteal fold. No entry was made for the last week in May.<br><br>The May 2008 MAR revealed no documentation that the EPC cream was applied to the gluteal fold on 5/3, 5, 10, 16, or 23/08. In addition, there was no documentation that an LN had assessed the wound daily for the entire month.<br><br>Nursing Notes and Interdisciplinary Care Notes were reviewed for May 2008. The record contained no documentation of the status of the open area to the right gluteal fold, measurements, | F 314 | F 314 (Continued from page 11)<br><br>related to Pressure Ulcer Prevention and Treatment.<br>• Review of Smith and Nephew skin and wound care protocols and licensed and CNA staff. Review of wound care protocols with licensed and CNA staff. Review of wound care protocol implementation and follow up education on 1:1 basis as needed.<br>• Specific weekly skin check assignments with DON/Consultant monitoring.<br>• Creation of wound care packet (includes all forms and procedures to follow when a wound is discovered) and inservicing of staff in use of packet.<br>• Implementation of weekly wound progress report to physician.<br>• Restorative staff will maintain an inventory log and tracking system for seating products and bed, as well as compiling the Manufacturer recommendations for use of each type of product.<br>• Notification of Dietary & Therapy for all skin concerns.<br>• Careplan update system has been revised to better reveal facility efforts in revision of careplans.<br>• All department managers will be required to review the 24 hour report | |

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| F 314 | Continued From page 12<br>or condition of surrounding tissue.<br><br>The May 2008 care plan was not updated to reflect any new skin issues or interventions.<br><br>A Condition Change Form, dated 6/6/08, stated, "Small open area less than 1 cm in diameter in the fold under R buttock."<br><br>A Weekly Skin Check form for June 2008 had entries for 6/5, 6/11, 6/20, and 6/24/08. The entry for 6/5/08 stated, "R buttock fold open area, cleansed. Skin is peeling on L[eft] Buttock. No other skin issues at this time. Will cont to monitor." The entry for 6/11 stated, "R buttock open area. Cleansed and new drsg applied." The entry for 6/20 stated, "No new skin issues to report." The entry for 6/24 stated, "Res[ident] has an open red area on L buttock fold area, cleansed well. Will cont to monitor." The notation an open area on the Left buttock appeared to be in error as the only other documented open area was to the Right gluteal fold.<br><br>The June 2008 MAR revealed no documentation that the EPC cream was applied to the gluteal fold on 6/1, 7, 8, 10, 13, 21, 22, 23, 27, or 30/08. In addition, there was no documentation that an LN had assessed the wound daily for the entire month.<br><br>The resident's quarterly MDS assessment, dated 3/16/08, coded the resident as being totally dependent on staff for bed mobility, transfers, and ADL's and documented no skin breakdown.<br><br>The most recent annual MDS, dated 6/10/08, identified Resident #1 as having abrasions or bruises but no pressure ulcers. The resident | F 314 | F314 (Continued from page 12)<br><br>and sign off indicating that they are aware of concerns. It is expected that they will take appropriate action, as needed.<br><br>4. Audits of weekly skin checks and appropriate wound care protocol implementation will be completed by DON/designee and Corporate Nurse Consultant. Audit of physician involvement will be completed by the RN Supervisor. Audit of physician visits will be completed by the Medical Records manager. Audit of appropriate infection control program implementation will be completed by the Infection Control Nurse. The IDT/MDS Coordinator will monitor careplan updates and notification/ involvement of all departments, as needed. The seating system and mattress inventory will be monitored by the Restorative and Therapy departments. The MDS Coordinator will monitor for changes in skin care status, and ensure that MDS is coded according to RAI manual. Specific audits have been assigned to staff. All staff with auditing responsibilities will provide a written summary to the Administrator for inclusion in the monthly QA Committee. The Administrator and DON will ensure that appropriate audits are | |

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| F 314 | Continued From page 13<br>coded as being totally dependent on staff for bed mobility, transfers and ADL's.<br><br>The June 2008 care plan was not updated from the initial 2005 care plan to reflect any new skin issues or interventions.<br><br>A Daily Monitoring Pressure/Non-Pressure Ulcers form was started on 6/27/08. The entry for 6/27/08 stated the pressure ulcer was "new". A measurement was taken of the gluteal wound on 6/27/08 and listed the dimensions as 1.2 cm long X 3 cm wide. This was the first measurement documented since the pressure ulcer was first recorded on 4/09/08. A box for "full thickness" was checked. The color was described, by a check mark, as red and epithelialized with a small amount of blood tinged exudate, and an odor. The box next to "treatment changed" was checked but the treatment was not listed. A second entry was made on the form for 6/27/08, listing a wound to the coccyx as 3 cm, partial thickness, with a red, epithelialized color, no exudate and no odor.<br><br>A Nutrition Assessment form, dated 6/30/08, was filled out for Resident #1. The current diet order listed was regular with no nutritional supplements. The Registered Dietitian's Recommendations stated, "No sig[nificant] changes, NT [nutrition] stable, PO [food intake by mouth] good... Sm [small] open area noted to R buttock, RD to follow, no need for dietary changes at this time."<br><br>A physician's order, dated 7/1/08, directed staff to, "Culture/swab wound to [right lower] buttock crease" and report the results of that laboratory test to the physician. That order was confirmed in | F 314 | F 314 (Continue from page 13)<br><br>completed. Specific audits and reporting will continue monthly for 3 months, then Quarterly.<br><br>5. Completion date: 9/5/08. | |

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| F 314 | Continued From page 14<br>an Interdisciplinary Progress Note (IDT Note) on 7/1/08 that read, "Received telephone call from [physician] regarding well being of resident. This nurse reported findings from this AM [morning] dressing [change] to [right] buttock. N.O. [New order] received for wound swab of area to be sent for culture."<br><br>A Care Plan Update, dated 7/1/08, identified the following Problem: "Res[ident] has an area to her [right] buttock crease. Possible infection. Approx[imately] 2.5 cm [centimeters] circular in the center of a known denuded area." The identified Goal documented, "Treat any underlying infection identified from wound swab." The Care Plan Update documented the following Approach: "1. Obtain wound swab as [ordered] 2. Review results [with physician] when available 3. Monitor for pain 4. Monitor for s/s [signs and symptoms] of infection, fever, etc. 5. Reassure resident as necessary."<br><br>A local hospital lab report of the resident's culture swab documented the wound tested positive for Methicillin Resistant Staph Aureus [MRSA] and Enterococcus faecalis bacteria on 7/7/08.<br><br>The Centers for Disease Control (CDC), recommended the following "patient placement" for residents in hospitals and long-term care facilities: "When single-patient rooms are available, assign priority for these rooms to patients [with] known or suspected MRSA colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission, e.g., uncontained secretions or excretions. When single-patient rooms are not available, cohort patients with the same MRSA in the same room or patient-care | F 314 | | |

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area. When cohorting patients with the same MRSA is not possible, place MRSA patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes from infection and are likely to have short lengths of stay. In general, in all types of healthcare facilities it is best to place patients requiring Contact Precautions in a single patient room." (Information about MRSA for Healthcare Personnel - CDC Infection Control in Healthcare. http://www.cdc.gov/ncidod/dhqp/ar_mrsa_healthcareFS.html.)

A physician's order dated 7/8/08 directed the facility to administer "TMP/SMX PO BID X 10 days [antibiotic by mouth twice daily for days] for "buttocks cellulitis." That order was confirmed by an IDT Note, dated 7/9/08.

A review of Resident #1's MAR, dated 7/9/08, revealed the antibiotic was administered BID for seven days from 7/9/08-7/15/08, once daily for 7/16/08 and 7/17/08, and was not administered on 7/18/08. In total, the MAR documented the resident missed four doses of the antibiotic ordered to treat MRSA.

A physician's order, dated 7/11/08, documented, "Wound care: Rx [Prescription] per wound protocol Idodosorb (sic: Iodosorb): to center area [and] cover with COPA hydrophilic foam dressing. [Change] dressing [every] 2-3 days and PRN. Apply [with] small amount gauze."

A Care Plan Update for Resident #1, dated 7/11/08, documented the following Problem: "Wound to [right] buttock crease. Change to dressing. Per facility protocol." The identified Goal documented, "Heal area to buttock. Reduce the

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risk of any further breakdown. Maintain skin integrity." The Care Plan Update documented the following Approaches: "1. Apply dressing as protocol. Measure [every] week. 2. Monitor and record dressing [every] day and PRN. 3. [Change] dressing [every] 2-3 days and PRN. 4. Assess for pain [every] shift and PRN. 5. Skin [checks every] week and PRN."

A July 2008 Daily Monitoring/Pressure Ulcers record for Resident #1 documented the dressing was changed according to the physician's order and Care Plan Update on 7/14, 7/17, and 7/29. However, the record indicated the resident's dressing was not changed as ordered and care planned on 7/20, 7/23, or 7/26.

A Resident Weekly Skin Check Sheet for Resident #1 documented that skin checks were conducted on 7/8, 7/11, 7/14, and 7/21. The following handwritten notes were documented on the weekly skin checks:

*7/8/08 - "Peri[neal] area very red. Open wound on [right] buttock fold. Bandage came off during shower. It needs to be replaced. Will continue to monitor."

* 7/11/08 - "Wound present to [right] gluteal fold also yeast, redness appears in groin [and] on thighs. New Tx's [treatments] started today for both areas."

* 7/14/08 - "Dressing to [right] gluteal changed. The area has deteriorated. Will cont[inue] to monitor. Also recorded on Daily Pressure Ulcer Sheet. Will cont[inue] to monitor."

* 7/21/08 - "No new skin issues at this time.

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| F 314 | Continued From page 17<br>Res[ident] cont[inues] to have dressing to [right] gluteal pressure ulcer. No drainage noted. Will cont[inue] to monitor."<br><br>* 7/29/08 - "Dressing to pressure ulcer changed. The wound has deteriorated since I saw it last. No new skin issues at this time."<br><br>August 2008 recapitulated physician orders for Resident #1 documented the EPC cream and Allevyn adhesive dressing were discontinued on 7/5/08 and 7/11/08 respectively. The orders included the following handwritten directive, dated 7/11/08: "Cleanse wound to [right] gluteal fold [with] wound cleanser or N/S [normal saline]. Pat off old Idodosorb [with] gauze (illegible) wound bed sl[ightly] moist. Apply Idodosorb to gauze cut smaller than hydrophilic foam. Place gauze on wound bed. Cover [with] foam. Use skin prep[aration] on edges. Wait till dry. Tape in place. [Change every] 2-3 days [and] PRN."<br><br>Resident #1's August MAR did not document the wound had been cleansed or dressing changed from 8/1/08 - 8/7/08. No other documentation was provided by the facility that indicated the wound had been cleansed or the dressing changed from 8/1/08 through the complaint investigation of 8/6-8/7/08.<br><br>A diagram dated 8/1/08 and provided to surveyors at the time of investigation included a hand drawn representation of the resident's right gluteal fold pressure ulcer. The diagram included a handwritten note that read, "3 cm circular open area wound is necrotic." The word "necrotic" was underlined. Under "details," was a handwritten note that documented, "The area to her buttock/this was noted on 7/5/08 at that time the | F 314 | | |

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area consisted mostly of denuded skin; however, the wound has declined and now as shown above. Referral to wound clinic requested." A second diagram of the wound, also dated 8/1/08, described the wound as "3 cm circular [and] 1.5 [centimeters] at deepest point." The second diagram also included the handwritten word "necrotic" with a drawn arrow pointing to a large area of the depicted wound.

An IDT Note, dated 8/1/08, documented, "[Resident #1's] wound has declined since this nurse last saw it. (Approx[imately] 2 weeks ago). The wound is 3 cm circular, with a 1 cm denuded area. At its deepest the wound [is] 1.5 cm deep. This accounts for approx 1/4 of the wound area ... The other 3/4 of the wound is approx 1 cm deep, all of the inner aspect of the wound appears 'necrotic.' This nurse advises that this [resident] would be best served with a wound clinic appointment."

Resident #1 received a referral on 8/1/08 to a local wound clinic, which was also faxed to the clinic on 8/1/08, according to a FAX coversheet provided by the facility. A return FAX from the wound clinic to the facility, dated 8/4/08, directed the facility to, "Please call to sched[ule] [an] appt [appointment]."

On 8/06/08, at 11:00 am, the resident's right gluteal pressure ulcer was observed by the surveyor and an LN. The intact dressing was totally covered with brown, dry drainage. The dressing was not dated. The LN indicated there was a foul odor when the dressing was removed. The LN staged the wound as a Stage IV due to eschar. The entire width of the wound was measured by the LN as 8.3 cm, with 4.0 cm

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covered with eschar, and the length as 5.4 cm. The quarter sized indentation in the center of the eschar was measured as 0.5 cm deep. The area surrounding the wound was not red or edematous. The resident did not complain of pain during the dressing change.

Immediately after the dressing change, the LN was interviewed. She stated she works on both sides of the building and everytime she has been gone or has worked on the opposite hall and came back to work with the resident the wound was bigger. The resident has had the wound for "many months" stated the LN.

A Physician Telephone Order, dated 8/6/08, directed staff to apply, "Wet to dry dressing BID to coccyx area. [Physician] to be here in am [morning] to debride area."

An IDT Note, dated 8/6/08, documented, "[Physician] will visit in the am to debride coccyx area. Continue to monitor for pain."

An IDT Note, dated 8/7/08, and signed by the resident's physician, documented, "Major concern is MRSA [and right] buttock wound for which she is on her 2nd course of TMP/SMX. Skin: 10 cm X [by] 10 cm Grade II ulcer over [right] buttock [with] tunneling 4 cm deep X 3 cm wide fanning out ... Necrotic tissue that we tried to remove today after irrigation with NSS [normal saline solution]. Grade I ulcer infer[ior] medial to above wound. Culture [positive] for E.Coli [Escherichia coli] and MRSA dated 7/2/8. Wound debrided partially and tunneling area filled ... [Right] buttock Grade III ulcer/multistage ulcer with [positive] MRSA and [positive] E.Coli. Wound care clinic referral for 8/13/08."

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| F 314 | Continued From page 20<br><br>On 8/6/08, at 1:25 p.m., and on 8/7/08 at 11:32 a.m., the resident's pressure relief mattress was inspected by surveyors. The pressure relief mattress was set for a resident weighing between 200 and 250-pounds during both observations. According to the facility's weight monitoring records, Resident #1 weighed approximately 169 pounds at the time of investigation. In an interview on 8/7/08, at 12:30 p.m., the DON stated the pressure relief mattress "wasn't set where it should be" to provide maximum pressure relief.<br><br>At the time of the complaint investigation, 8/6-8/7/08, Resident #1 was observed repeatedly in her room. Surveyors did not observe staff practicing contact precautions or any signs in the facility that notified staff or visitors that contact isolation precautions were in effect for Resident #1. Additionally, no staff member during the course of the complaint investigation advised surveyors that the resident was under contact isolation precautions for MRSA.<br><br>On 8/7/08, at 11:30 p.m., the resident's wheelchair cushion was observed by surveyors. The cushion included a pommel in the front center intended to help prevent the resident from sliding forward in the wheelchair, was approximately three-inches thick, and was made of foam with a vinyl cover.<br><br>On 8/7/08, at 12:05 p.m., the facility's physical therapist provided surveyors with a copy of a catalog photograph and description of the cushion in Resident #1's wheelchair. The description read, "Designed for slide control and hip abduction ..." According to the catalog description, the cushion | F 314 | | |

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| F 314 | Continued From page 21<br>was not designed for relieving pressure.<br><br>On 8/7/08, at 1:52 p.m., one of the facility's owners and the physical therapy staff showed surveyors an "interim" wheelchair cushion the owner described as "the best we have in-house." The owner and physical therapy staff informed surveyors the resident's wheelchair cushion would be replaced with the interim cushion until a "state-of-the-art" pressure-relieving cushion arriving later that day could be provided to the resident.<br><br>On 8/7/08, at 12:30 p.m., the facility's Administrator, DON, Corporate Vice President, and owners were interviewed and questioned about the lack of contact isolation precautions to prevent the spread of Resident #1's MRSA to other residents, or signs warning other residents, staff, and visitors of MRSA contact precautions for Resident #1. The DON stated the resident was placed on contact precautions, but "I don't know why it wasn't documented."<br><br>During the 8/7/08 interview, the facility's Administrator, DON, Corporate Vice President, and owners were asked about the 3/17/08 pressure ulcer risk assessment that placed the resident as a "low risk" for skin impairment despite a long history of compromise, limited mobility, risk for friction and shearing from transfers, and bed- or chairbound status. The vice president stated the score was based on history and physical assessment conducted by nursing staff at the facility.<br><br>When asked about the MAR that indicated Resident #1 was not given four antibiotic treatments, the vice president and owner stated | F 314 | | |

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| F 314 | Continued From page 22<br>the resident did receive the ordered dosages of antibiotic treatments. Documentation was provided that indicated no TMP/SMX antibiotic doses were returned to the facility's pharmacy. However, the facility was asked for but did not provide documentation that the four doses of antibiotic treatment were administered.<br><br>During the 8/7/08 interview, the facility provided surveyors with a copy of its Condensed Wound Protocol. Under, Tracking Current Wounds, the facility's protocol documented: "1. Assess and measure wound weekly per schedule. 2. Make a note in chart on wound care record in binder. 3. Evaluate efficacy of current treatment. If not effective after 1-2 weeks (LN judgement) then discuss need for new treatment with LPN, DNS, MD [Medical Director] ... 4. If new treatment ordered, use 3 part form and add to copy and text sheet. 5. Record all on Wound Care Log in binder."<br><br>When asked about the lacking documentation pertaining to wound assessment and measurement, notes on wound care, evaluation of current treatments per commonly accepted standards of practice and the facility's own protocol and Care Plan updates, the vice president stated, "[Resident #1's LN] should have started daily monitoring [and] it's part of the system" to update Care Plans when skin breakdowns occurred.<br><br>Resident #1 was admitted to the facility with a high risk for, and history of, pressure ulcers and care planned for skin integrity interventions that did not change over the course of her three year residency at the facility. In 2008, the resident developed an "open area" to the right gluteal fold | F 314 | | |

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| F 314 | Continued From page 23<br>that progressed to a Stage IV pressure ulcer with necrotic tissue. The facility's own protocols and physician's orders to assess the wound daily and treat according to order were not followed in April 2008 and the Care Plan was not updated to reflect the development of a skin impairment. Weekly skin checks in May 2008 contained no reference to the resident's worsening pressure ulcer, and records documented the wound was not assessed or treated as physician ordered. Also in May 2008, Resident #1's Care Plan was not updated and nursing notes did not include any documentation regarding the wound. In June 2008, the facility failed to assess or treat the wound as ordered, according to its records, and the resident's Care Plan was not updated. Also in June 2008, Resident #1's annual MDS assessment did not identify the presence of a pressure ulcer, but coded the resident as having bruises or abrasions. Dietary changes to assist with skin wound healing were not implemented at any time during the development of the resident's pressure ulcer to the right gluteal fold, the resident's bed was not inflated to a level that would maximize pressure relief to the affected area, the resident's wheelchair cushion was not designed to relieve pressure, and no contact isolation procedures or precautions were put into place to protect against the spread of MRSA to staff or other residents. | F 314 | | |
| F 385 SS=D | 483.40(a) PHYSICIAN SERVICES<br><br>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.<br><br>The facility must ensure that the medical care of each resident is supervised by a physician; and | F 385 | F 385<br><br>1. The attending physician for Resident #1 was notified of changes in wound status and visited the resident at the facility prior to the survey team exiting the facility. Orders for wound care were received and a progress note was written at that time. The MD has been notified about the changes in the resident's status as well as receiving weekly wound progress reports. The physician and staff at the Center for | |

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| F 385 | Continued From page 24<br>another physician supervises the medical care of residents when their attending physician is unavailable.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure that the medical care of a resident was adequately supervised by a physician. This was true for 1 of 4 sampled residents (# 1). Findings include:<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses including multiple sclerosis, depressive disorder, and calculus of the kidney.<br><br>The Resident Weekly Skin Check Sheet, dated 04/09/08, documented, "Open area noted to gluteal fold on R. (right) cream applied."<br><br>A physician's order, dated 04/12/08, directed staff to, "Apply EPC cream to R gluteal fold. CNA may apply, LN to assess q (every) day."<br><br>The May Nursing Notes and Interdisciplinary Care Notes were reviewed and contained no documentation of the status of an open area to the right gluteal fold, measurements, or condition of surrounding tissue.The April, May, and June care plans were not updated to reflect any new skin issues or interventions. The April, May, and June MARS had missing documentation for the application of the EPC skin cream, and there was no documentation that an LN had assessed the wound daily.<br><br>A Condition Change Form, dated 6/6/08, stated, | F 385 | F 385 (Continued from page 24)<br><br>Wound Healing at St. Luke's Meridian have also been involved in the care of Resident #1.<br><br>2. All residents could be affected by this deficient practice. The Medical Records manager completed an audit of all physician visits. The Administrator sent a letter to all participating physicians apprising them of the citation received by the facility related to physician services. Specific physicians were alerted of any outstanding visits as well as the date of expected completion. For all skin concerns noted, resident physicians have been notified and will be sent weekly wound progress reports as well.<br><br>3. The Medical Director was apprised of the outcome of the survey. The attending physician for Resident #1 will be receiving notification from CMS related to the findings of the survey. (His name and address has been provided to the Bureau of Facility Standards.) The Medical Records manager will continue to audit physician compliance with visits. Any deviation will be brought to the appropriate physician's attention. If the concerns are not corrected, the Administrator will contact the physician (and MD if | |

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| F 385 | Continued From page 25<br>"Small open area less than 1 cm in diameter in the fold under R buttock."<br><br>A Weekly Skin Check form for June 2008 had entries for 6/5, 6/11, 6/20, and 6/24/08. The entry for 6/5/08 documented, "R buttock fold open area, cleansed. Skin is peeling on L[eft] Buttock. No other skin issues at this time. Will cont[inue] to monitor." The entry for 6/11/08 documented, "R buttock open area. Cleansed and new drsg [dressing] applied." The entry for 6/20/08 documented, "No new skin issues to report." The entry for 6/24/08 documented, "Res[ident] has an open red area on L buttock fold area, cleansed well. Will cont[inue] to monitor." The notation an open area on the left buttock appeared to be in error as the only other documented open area was to the right gluteal fold.<br><br>A Daily Monitoring Pressure/Non-Pressure Ulcers form was started on 6/27/08. The entry for 6/27/08 stated the pressure ulcer was "new." A measurement was taken of the gluteal wound on 6/27/08 and listed the dimensions as 1.2 cm long X 3 cm wide. This was the first measurement documented since the pressure ulcer was first recorded on 04/09/08. A box for "full thickness" was checked. The color was described, by a check mark, as red and epithelialized with a small amount of blood tinged exudate, and an odor. The box next to "treatment changed" was checked but the treatment was not listed. A second entry was made on the form for 6/27/08, listing a wound to the coccyx as 3 cm, partial thickness, with a red, epithelialized color, no exudate and no odor.<br><br>The resident's record did not document any physicians visits or follow-up calls in April, May, or | F 385 | F 385 (Continue from page 25)<br>necessary) to request cooperation in a timely manner. Licensed Nurses and IDT members have been inserviced regarding need to contact physicians for changes in resident status. The RN Supervisors will monitor for physician notification of changes in resident status, and follow up to ensure notification is completed. The RN Supervisors will maintain a concern log for physicians to review during rounds. Records will be reviewed to ensure physicians have signed and dated progress notes after each visit.<br><br>4. The Medical Records manager will provide a monthly report to the QA Committee related to physician visits. The RN Supervisor will assist the DON in providing an audit of staff compliance with notification of physician physicians concerning changes in resident status. Results of audits will be presented at the monthly QA Committee meetings. Corporate Nurse Consultants will monitor compliance on a monthly basis for 3 months, and then Quarterly.<br><br>5. Completion date: 9/5/08. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMMETT REHAB & HEALTHCARE INC | 714 NORTH BUTTE AVENUE EMMETT, ID 83617 |

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| F 385 | Continued From page 26 | F 385 | | |

June to monitor the resident's status.

A physician's order for Resident #1, dated 7/1/08, directed staff to, "Culture/swab wound to [right lower] buttock crease" and report the results of that laboratory test to the physician. That order was confirmed in an Interdisciplinary Progress Note (IDT Note) on 7/1/08 that read, "Received telephone call from [physician] regarding well being of resident. This nurse reported findings from this AM [morning] dressing [change] to [right] buttock. N.O. [New order] received for wound swab of area to be sent for culture."

A Care Plan Update, dated 7/1/08, identified the following Problem: "Res[ident] has an area to her [right] buttock crease. Possible infection. Approx[imately] 2.5 cm [centimeters] circular in the center of a known denuded area." The identified Goal documented, "Treat any underlying infection identified from wound swab." The Care Plan Update documented the following Approach: "1. Obtain wound swab as [ordered] 2. Review results [with physician] when available 3. Monitor for pain 4. Monitor for s/s [signs and symptoms] of infection, fever, etc. 5. Reassure resident as necessary."

A local hospital lab report of the resident's culture swab documented the wound tested positive for Methicillin Resistant Staph Aureus [MRSA] and Enterococcus faecalis bacteria on 7/7/08.

A physician's order, dated 7/8/08, directed the facility to administer "TMP/SMX PO BID X 10 days [antibiotic by mouth twice daily for 10 days] for "buttocks cellulitis." That order was confirmed by an IDT Note, dated 7/9/08.

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| F 385 | Continued From page 27 | F 385 | | |

A physician's order, dated 7/11/08, documented, "Wound care: Rx [Prescription] per wound protocol Idodosorb: to center area [and] cover with COPA hydrophilic foam dressing. [Change] dressing [every] 2-3 days and PRN [as needed]. Apply [with] small amount gauze."

A July 2008 Daily Monitoring/Pressure Ulcers record for Resident #1 documented the dressing was changed according to the physician's order and Care Plan Update on 7/14, 7/17, and 7/29. However, the record indicated the resident's dressing was not changed as ordered and care planned, on 7/20, 7/23, or 7/26.

* 7/11/08 - "Wound present to [right] gluteal fold also yeast, redness appears in groin [and] on thighs. New Tx's [treatments] started today for both areas."

* 7/21/08 - "No new skin issues at this time. Res[ident] cont[inues] to have dressing to [right] gluteal pressure ulcer. No drainage noted. Will cont[inue] to monitor."

* 7/29/08 - "Dressing to pressure ulcer changed. The wound has deteriorated since I saw it last. No new skin issues at this time."

August 2008 recapitulated physician orders for Resident #1 documented the EPC cream and Allevyn adhesive dressing were discontinued on 7/5/08 and 7/11/08 respectively. The orders included the following handwritten directive, dated 7/11/08: "Cleanse wound to [right] gluteal fold [with] wound cleanser or N/S [normal saline]. Pat off old Idodosorb [with] gauze (illegible) wound bed sl[ightly] moist. Apply Idodosorb to gauze cut smaller than hydrophilic foam. Place gauze on

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| F 385 | Continued From page 28<br>wound bed. Cover [with] foam. Use skin prep[aration] on edges. Wait till dry. Tape in place. [Change every] 2-3 days [and] PRN."<br><br>The resident's record does not document any physicians visits, follow-up calls, subsequent cultures of wound, or new treatments between 07/11/08 and 08/07/08.<br><br>A diagram dated 8/1/08 and provided to surveyors at the time of investigation included a hand drawn representation of the resident's right gluteal fold pressure ulcer. The diagram included a handwritten note that read, "3 cm circular open area wound is necrotic." The word "necrotic" was underlined. Under "details," was a handwritten note that documented, "The area to her buttock/this was noted on 7/5/08 at that time the area consisted mostly of denuded skin; however, the wound has declined and now as shown above. Referral to wound clinic requested." A second diagram of the wound, also dated 8/1/08, described the wound as "3 cm circular [and] 1.5 [centimeters] at deepest point." The second diagram also included the handwritten word "necrotic" with a drawn arrow pointing to a large area of the depicted wound.<br><br>An IDT Note, dated 8/1/08, documented, "[Resident #1's] wound has declined since this nurse last saw it. (Approx[imately] 2 weeks ago). The wound is 3 cm circular, with a 1 cm denuded area. At its deepest the wound [is] 1.5 cm deep. This accounts for approx 1/4 of the wound area ... The other 3/4 of the wound is approx 1 cm deep, all of the inner aspect of the wound appears 'necrotic.' This nurse advises that this [resident] would be best served with a wound clinic appointment." | F 385 | | |

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| F 385 | Continued From page 29<br><br>Resident #1 received a referral to a local wound clinic, which was faxed to the clinic on 8/1/08, according to a FAX coversheet provided by the facility. A return FAX from the wound clinic to the facility, dated 8/4/08, directed the facility to, "Please call to sched[ule] [an] appt [appointment]."<br><br>The Interdisciplinary Progress Notes dated 08/04/08, documented, "Paperwork has been faxed to the Wound clinic [after] obtaining signed order. Awaiting call to schedule appt."<br><br>The physician faxed the referral to the wound clinic on 08/01/08, but did not assess the resident's status or treatments when called by the facility.<br><br>On 08/06/08, at 11:00 am, the resident's right gluteal pressure ulcer was observed by the surveyor and an LN. The dressing was intact and saturated with dried brown drainage. The dressing was not dated. The LN indicated there was a foul odor when the dressing was removed. The LN staged the wound as a Stage IV due to eschar. The entire width of the wound was measured by the LN as 8.3 cm, with 4.0 cm covered with eschar, and the length as 5.4 cm. The quarter sized indentation in the center of the eschar was measured as 0.5 cm deep. The area surrounding the wound was not red or edematous. The resident did not complain of pain during the dressing change.<br><br>Immediately after the dressing change, the LN was interviewed. She stated she was assigned to both sides of the building and that when she does not work or has worked on the opposite hall and | F 385 | | |

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| F 385 | Continued From page 30<br>then returned to Resident #1's hall, the wound had grown larger. The LN stated that the resident had the wound for "many months."<br><br>On 08/06/08, the DON confirmed she scheduled a wound care clinic appointment for the resident on 08/13/08.<br><br>A Physician Telephone Order, dated 8/6/08, directed staff to apply, "Wet to dry dressing BID to coccyx area. [Physician] to be here in am [morning] to debride area."<br><br>An Interdisciplinary Progress notes, dated 08/06/08 documented an order was received from the physician for TMP/SMX antibiotics to be given by mouth twice daily for ten days for a buttock wound.<br><br>An IDT Note, dated 8/6/08, documented, "[Physician] will visit in the am to debride coccyx area. Continue to monitor for pain."<br><br>An IDT Note, dated 8/7/08, and signed by the resident's physician, documented, "Major concern is MRSA [and right] buttock wound for which she is on her 2nd course of TMP/SMX. Skin: 10 cm X [by] 10 cm Grade II ulcer over [right] buttock [with] tunneling 4 cm deep X 3 cm wide fanning out ... Necrotic tissue that we tried to remove today after irrigation with NSS [normal saline solution]. Grade I ulcer infer[ior] medial to above wound. Culture [positive] for E.Coli [Escherichia coli] and MRSA dated 7/2/8. Wound debrided partially and tunneling area filled ... [Right] buttock Grade III ulcer/multistage ulcer with [positive] MRSA and [positive] E.Coli. Wound care clinic referral for 8/13/08." | F 385 | | |

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| F 385 | Continued From page 31<br>On 8/7/08, at 12:00 pm, the DON and Nurse Consultant were interviewed regarding the lack of physician visits. The DON stated that she was unsure if the physician had visited the resident to assess the wound prior to 8/7/08. The Nurse Consultant looked through the resident's record, and stated the 8/7/08 visit was the first day the resident had been assessed by the physician.<br><br>The physician failed to adequately supervise the medical care of the resident. He did not participate in the assessment, care planning, or monitoring the changes in the resident's medical status when called by the facility. | F 385 | | |
| F 441 SS=E | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record review, it was determined the facility failed to protect residents from communicable infection by not exercising contact precautions for a resident with methicillin-resistant Staphylococcus aureus (MRSA) in accordance with accepted standards of practice. This had the potential to affect any resident, staff, or visitor who came into | F 441 | F 441<br><br>1. Resident #1 has been placed in contact isolation. Red bags and appropriate signage have been implemented. The roommate for Resident #1 was tested for MRSA and had no signs of infection. She was moved out of the room and has since been discharged from the facility.<br><br>2. All other residents could be affected by the deficient practice. One other resident has been identified to have active MRSA. She is in a room by herself and has been placed on Contact Isolation precautions with red bags and appropriate signage.<br><br>3. Staff have been inserviced related to appropriate care of residents with MRSA. The Infection Control Nurse has | |

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| F 441 | Continued From page 32<br>contact with the resident, as well as any subsequent resident and other individuals who in turn came into contact with those residents, staff, or visitors. Findings include:<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses of multiple sclerosis, depressive disorder, and calculus of the kidney.<br><br>A Weekly Skin Check form, dated 4/9/08, documented, "Open area noted to gluteal fold on R [right]." A Weekly Skin Check form, dated 4/16/08, documented, "Cont[inues] to have sm [small] open area on R [right] Glut[eal] fold.<br><br>A Condition Change Form, dated 6/6/08, documented, "Small open area less than 1 cm [centimeter] in diameter in the fold under R [right] buttock."<br><br>A Daily Monitoring Pressure/Non-Pressure Ulcers form begun on 6/27/08, documented a wound to the gluteal fold on that date that measured 1.2 cm long by 3 cm wide. This was the first measurement documented since the pressure ulcer was first recorded on 4/9/08. A box for "full thickness" was checked. The color was described, by a check mark, as red and epithelialized with a small amount of blood-tinged exudate, and an odor.<br><br>A physician's order for the resident, dated 7/1/08, directed staff to, "Culture/swab wound to [right lower] buttock crease," and report the results of that laboratory test to the physician.<br><br>A Care Plan Update, dated 7/1/08, identified the following Problem: "Res[ident] has an area to her [right] buttock crease. Possible infection. | F 441 | F 441 (Continued from page 32)<br><br>been instructed about the procedures to be implemented when positive MRSA cultures are noted. She will complete an audit to ensure that appropriate precautions have been implemented, as infections are identified. This audit will be forwarded to the DON for each resident affected by MRSA.<br><br>4. Monthly Infection Control reports will identify residents with MRSA. Infection Control Nurse and DON will ensure that appropriate measures have been implemented. A report of findings and interventions will be provided at the monthly QA Committee meeting by the Infection Control Nurse. This will be ongoing.<br><br>5. Completion date: 9/5/08. | |

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| F 441 | Continued From page 33 | F 441 | | |

Approx[imately] 2.5 cm circular in the center of a known denuded area." The identified Goal documented, "Treat any underlying infection identified from wound swab." The Care Plan Update documented the following Approach: "1. Obtain wound swab as [ordered]. 2. Review results [with physician] when available. 3. Monitor for pain. 4. Monitor for s/s [signs and symptoms] of infection, fever, etc. 5. Reassure resident as necessary."

A local hospital lab report of the resident's culture swab documented the wound tested positive for MRSA and Enterococcus faecalis bacteria on 7/7/08.

The Centers for Disease Control (CDC), recommended the following "patient placement" for residents in hospitals and long-term care facilities: "When single-patient rooms are available, assign priority for these rooms to patients [with] known or suspected MRSA colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission, e.g., uncontained secretions or excretions. When single-patient rooms are not available, cohort patients with the same MRSA in the same room or patient-care area. When cohorting patients with the same MRSA is not possible, place MRSA patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes from infection and are likely to have short lengths of stay. In general, in all types of healthcare facilities it is best to place patients requiring Contact Precautions in a single patient room." (Information about MRSA for Healthcare Personnel - CDC Infection Control in Healthcare. http://www.cdc.gov/ncidod/dhqp/ar_mrsa_healthc

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| F 441 | Continued From page 34<br>areFS.html.)<br><br>An Interdisciplinary Team note (IDT), dated 8/7/08, and signed by the resident's physician, documented, "Major concern is MRSA [and right] buttock wound for which she is on her 2nd course of TMP/SMX [antibiotic] ... Culture [positive] for E. Coli [Escherichia coli bacteria] and MRSA dated 7/2/8 ... [Right] buttock Grade III ulcer/multistage ulcer with [positive] MRSA and [positive] E. Coli."<br><br>At no time during investigation did surveyors observe or receive warnings from staff regarding Resident #1's status as a MRSA-positive resident with contact precautions in effect. Resident #1 was observed repeatedly throughout the investigation in her room, which she shared with a roommate.<br><br>On 8/7/08, at 12:30 p.m., the facility's Administrator, DON, Corporate Vice President, and owners were interviewed and questioned about the lack of of contact isolation precautions to prevent the spread of Resident #1's MRSA to other residents, and why the facility did not post signs warning other residents, staff, and visitors of MRSA contact precautions for Resident #1. The DON stated the resident was placed on contact precautions, but "I don't know why it wasn't documented." | F 441 | | |

PRINTED: 08/21/2008
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| C 000 | 16.03.02 INITIAL COMMENTS<br><br>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.<br>The following deficiencies were cited during a complaint investigation at your facility.<br><br>The surveyors conducting the survey were:<br><br>David Scott, RN<br>Amanda Bain, RN<br>Kari Davies, MPH, RD, LD | C 000 | | |
| C 643 | 02.150,01 INFECTION CONTROL<br><br>150. INFECTION CONTROL.<br><br>01. Policies and Procedures. Policies and procedures shall be written which govern the prevention, control and investigation of infections. They shall include at least:<br>This Rule: Is not met as evidenced by:<br>Please refer to F441 as it refers to infection control. | C 643 | C 643 02.150,01<br>See F 441<br>Date: 9/5/08 | |
| C 779 | 02.200,03,a,i<br><br>i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses;<br>This Rule: Is not met as evidenced by:<br>Please refer to F272 as it relates to comprehensive resident assessments. | C 779 | C 779 02.200,03,a,i<br>See F 272<br>Date: 9/5/08 | |
| C 782 | 02.200,03,a,iv | C 782 | | |

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/30/08

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| C 782 | Continued From page 1<br><br>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished;<br>This Rule is not met as evidenced by:<br>Please refer to F280 as it refers to revising care plans as needed. | C 782 | C 782 02.200,03,a,iv<br>See F 280<br>Date: 9/5/08 | |
| C 789 | 02.200,03,b,v<br><br>v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation;<br>This Rule is not met as evidenced by:<br>Based on observations, interviews, record review, and a complaint from the general public, it was determined the facility failed to prevent, treat, and monitor pressure ulcers for one of four [#1] sampled residents. This resulted in serious injury endangering the health of Resident #1, who developed a preventable stage IV pressure ulcer. The failure of the facility to appropriately assess, treat, and monitor skin care issues had the potential to affect all residents with, or at risk for, pressure ulcers.<br><br>This situation was brought to the attention of the facility on 8/7/08 at 1:15 pm, at which time the facility was provided with specific details of the failure to prevent a pressure ulcer.<br><br>The facility provided an acceptable plan of correction to the surveyors on 8/7/08 at 2:20 pm, at which time the endangerment was abated. The plan of correction is as follows: | C 789 | C 789 02.200,03,b,v<br>See F 314<br>Date: 9/5/08 | |

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| C 789 | Continued From page 2<br><br>1. Resident #1's Physician came into the building on 8/7/08 to examine and debride the right buttock wound. The facility's staff would send the physician weekly measurements and wound assessments.<br>2. An appointment at a wound clinic was scheduled for August 13.<br>3. New dressing change ordered.<br>4. Resident #1 was placed in contact isolation.<br>5. A new air bed and pressure relief cushion were ordered for Resident #1.<br><br>Resident #1 was admitted to the facility on 10/1/05 with diagnoses including multiple sclerosis, depressive disorder, and calculus of the kidney.<br><br>Resident #1's admission MDS, dated 10/7/05, coded a stage III pressure ulcer.<br><br>A Skin Integrity Impairment form for Resident #1, dated 10/1/05, identified the problem of "Skin integrity impaired...Sacrum breakdown, stage 3 noted on admit." The listed interventions included:<br>*Air mattress,<br>*Pressure reduction cushion to bedside chair and/or wheelchair/geri chair,<br>*Follow in wound team rounds, ensure pain management program is effective,<br>*Use turn sheet for repositioning,<br>*Daily skin inspection during cares. Notify LN of skin integrity impairments,<br>*Weekly licensed nurse skin assessment, and<br>*Weekly check for "bottoming out" in w/c [wheelchair] and/or bed.<br><br>A Weekly Pressure Ulcer Condition Report, with dated entries of 10/2/05 and 10/9/05, | C 789 | | |

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| C 789 | Continued From page 3<br><br>documented Resident #1's sacral wound. The entry for 10/2/05 stated the wound was a stage III with a distinct outline, absence of necrotic tissue, a scant amount of serosanguineous exudate, and minimal edema of the surrounding tissues. The treatment was "DuoDerm placed for protection." The entry for 10/9/05 stated the wound was "now closed" and the DuoDerm was discontinued.<br><br>Resident #1's initial care plan, dated 10/14/05, listed the problem of "Skin integrity impaired." The approaches listed were:<br>*Turn and reposition per policy,<br>*Skin checks per facility policy,<br>*Examine skin with cares. Notify LN of any red/open areas.<br><br>A care plan update, dated 10/14/05 clarified, "Place DuoDerm over areas Q wk and PRN [every week and as needed], turning schedule Q2 hours and PRN, encourage resident to comply with cares and hydration/nutrition."<br><br>The initial care plan, dated 10/14/05, was not updated to include changes in skin integrity until 07/01/08.<br><br>The initial Pressure Ulcer Risk Assessment Tool for Resident #1, dated 1/5/06, scored the resident at a high risk for skin breakdown due to: history of healed pressure ulcer, pain, H/O MS [history of multiple sclerosis].<br><br>The Pressure Ulcer Risk Assessments, dated 2/9/07 and 3/17/08, scored the resident as a low risk for skin breakdown despite having a history of pressure ulcers, being bed and chair bound, totally reliant on staff for ADL's and repositioning, indwelling catheter, and previously been scored as a high risk on the same assessment tool. | C 789 | | |

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| C 789 | Continued From page 4<br><br>A Weekly Skin Check form for February 2008 had entries for 2/3, 2/9, 2/17, and 2/23/08. Each entry stated the resident's skin integrity was intact and there were no new skin issues.<br><br>A Weekly Skin Check form for April 2008 included an entry dated 4/2/08, which stated, "No new skin issues at this time."An entry for 4/9/08 stated, "Open area noted to gluteal fold on R [right]. Cream applied." An entry for 4/16/08 stated, "Cont to have sm [small] open area on R Glut[eal] fold. Protective cream applied. Will cont[inue] to monitor." No measurements or other entries were made for April 2008.<br><br>A Documentation Record Comments form, dated 4/13/08, stated, "After shower LN did a skin check on resident and we found her bottom was open and slightly bleeding."<br><br>A physician's order was received on 4/12/08 to "Apply EPC cream to R gluteal fold. CNA may apply, LN to assess Q [every] day." The MAR revealed no documentation that the cream was applied on 4/3, 5, 10, 16, or 23. In addition, no documentation was found to indicate the LN did daily wound assessment on 4/16, 17, 18, 19, and 22 through the end of the month.<br><br>The April 2008 care plan for Resident #1 was not updated to reflect the new skin issues or the interventions to be implemented.<br><br>A Weekly Skin Check form for May 2008 had entries for 5/4, 5/15, and 5/21. The entry for 5/4 stated, "Peri area. Cocyx [sic] cracked, cream applied." The entry for 5/15 stated, "No new issues, peri area better." No mention was made of the open area to the gluteal fold. The entry for | C 789 | | |

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| C 789 | Continued From page 5<br><br>5/21 stated, "No new issues noted." Again, no mention was made of the open area to the gluteal fold. No entry was made for the last week in May.<br><br>The May 2008 MAR revealed no documentation that the EPC cream was applied to the gluteal fold on 5/3, 5, 10, 16, or 23/08. In addition, there was no documentation that an LN had assessed the wound daily for the entire month.<br><br>Nursing Notes and Interdisciplinary Care Notes were reviewed for May 2008. The record contained no documentation of the status of the open area to the right gluteal fold, measurements, or condition of surrounding tissue.<br><br>The May 2008 care plan was not updated to reflect any new skin issues or interventions.<br><br>A Condition Change Form, dated 6/6/08, stated, "Small open area less than 1 cm in diameter in the fold under R buttock."<br><br>A Weekly Skin Check form for June 2008 had entries for 6/5, 6/11, 6/20, and 6/24/08. The entry for 6/5/08 stated, "R buttock fold open area, cleansed. Skin is peeling on L[eft] Buttock. No other skin issues at this time. Will cont to monitor." The entry for 6/11 stated, "R buttock open area. Cleansed and new drsg applied." The entry for 6/20 stated, "No new skin issues to report." The entry for 6/24 stated, "Res[ident] has an open red area on L buttock fold area, cleansed well. Will cont to monitor." The notation an open area on the Left buttock appeared to be in error as the only other documented open area was to the Right gluteal fold.<br><br>The June 2008 MAR revealed no documentation | C 789 | | |

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| C 789 | Continued From page 6<br><br>that the EPC cream was applied to the gluteal fold on 6/1, 7, 8, 10, 13, 21, 22, 23, 27, or 30/08. In addition, there was no documentation that an LN had assessed the wound daily for the entire month.<br><br>The resident's quarterly MDS assessment, dated 3/16/08, coded the resident as being totally dependent on staff for bed mobility, transfers, and ADL's and documented no skin breakdown.<br><br>The most recent annual MDS, dated 6/10/08, identified Resident #1 as having abrasions or bruises but no pressure ulcers. The resident coded as being totally dependent on staff for bed mobility, transfers and ADL's.<br><br>The June 2008 care plan was not updated from the initial 2005 care plan to reflect any new skin issues or interventions.<br><br>A Daily Monitoring Pressure/Non-Pressure Ulcers form was started on 6/27/08. The entry for 6/27/08 stated the pressure ulcer was "new". A measurement was taken of the gluteal wound on 6/27/08 and listed the dimensions as 1.2 cm long X 3 cm wide. This was the first measurement documented since the pressure ulcer was first recorded on 4/09/08. A box for "full thickness" was checked. The color was described, by a check mark, as red and epithelialized with a small amount of blood tinged exudate, and an odor. The box next to "treatment changed" was checked but the treatment was not listed. A second entry was made on the form for 6/27/08, listing a wound to the coccyx as 3 cm, partial thickness, with a red, epithelialized color, no exudate and no odor.<br><br>A Nutrition Assessment form, dated 6/30/08, was | C 789 | | |

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| C 789 | Continued From page 7<br><br>filled out for Resident #1. The current diet order listed was regular with no nutritional supplements. The Registered Dietitian's Recommendations stated, "No sig[nificant] changes, NT [nutrition] stable, PO [food intake by mouth] good... Sm [small] open area noted to R buttock, RD to follow, no need for dietary changes at this time."<br><br>A physician's order, dated 7/1/08, directed staff to, "Culture/swab wound to [right lower] buttock crease" and report the results of that laboratory test to the physician. That order was confirmed in an Interdisciplinary Progress Note (IDT Note) on 7/1/08 that read, "Received telephone call from [physician] regarding well being of resident. This nurse reported findings from this AM [morning] dressing [change] to [right] buttock. N.O. [New order] received for wound swab of area to be sent for culture."<br><br>A Care Plan Update, dated 7/1/08, identified the following Problem: "Res[ident] has an area to her [right] buttock crease. Possible infection. Approx[imately] 2.5 cm [centimeters] circular in the center of a known denuded area." The identified Goal documented, "Treat any underlying infection identified from wound swab." The Care Plan Update documented the following Approach: "1. Obtain wound swab as [ordered] 2. Review results [with physician] when available 3. Monitor for pain 4. Monitor for s/s [signs and symptoms] of infection, fever, etc. 5. Reassure resident as necessary."<br><br>A local hospital lab report of the resident's culture swab documented the wound tested positive for Methicillin Resistant Staph Aureus [MRSA] and Enterococcus faecalis bacteria on 7/7/08.<br><br>The Centers for Disease Control (CDC), | C 789 | | |

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| C 789 | Continued From page 8<br><br>recommended the following "patient placement" for residents in hospitals and long-term care facilities: "When single-patient rooms are available, assign priority for these rooms to patients [with] known or suspected MRSA colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission, e.g., uncontained secretions or excretions. When single-patient rooms are not available, cohort patients with the same MRSA in the same room or patient-care area. When cohorting patients with the same MRSA is not possible, place MRSA patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes from infection and are likely to have short lengths of stay. In general, in all types of healthcare facilities it is best to place patients requiring Contact Precautions in a single patient room." (Information about MRSA for Healthcare Personnel - CDC Infection Control in Healthcare. http://www.cdc.gov/ncidod/dhqp/ar_mrsa_healthcareFS.html.)<br><br>A physician's order dated 7/8/08 directed the facility to administer "TMP/SMX PO BID X 10 days [antibiotic by mouth twice daily for days] for "buttocks cellulitis." That order was confirmed by an IDT Note, dated 7/9/08.<br><br>A review of Resident #1's MAR, dated 7/9/08, revealed the antibiotic was administered BID for seven days from 7/9/08-7/15/08, once daily for 7/16/08 and 7/17/08, and was not administered on 7/18/08. In total, the MAR documented the resident missed four doses of the antibiotic ordered to treat MRSA.<br><br>A physician's order, dated 7/11/08, documented, "Wound care: Rx [Prescription] per wound | C 789 | | |

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| C 789 | Continued From page 9 | C 789 | | |

protocol Idodosorb (sic: Iodosorb): to center area [and] cover with COPA hydrophilic foam dressing. [Change] dressing [every] 2-3 days and PRN. Apply [with] small amount gauze."

A Care Plan Update for Resident #1, dated 7/11/08, documented the following Problem: "Wound to [right] buttock crease. Change to dressing. Per facility protocol." The identified Goal documented, "Heal area to buttock. Reduce the risk of any further breakdown. Maintain skin integrity." The Care Plan Update documented the following Approaches: "1. Apply dressing as protocol. Measure [every] week. 2. Monitor and record dressing [every] day and PRN. 3. [Change] dressing [every] 2-3 days and PRN. 4. Assess for pain [every] shift and PRN. 5. Skin [checks every] week and PRN."

A July 2008 Daily Monitoring/Pressure Ulcers record for Resident #1 documented the dressing was changed according to the physician's order and Care Plan Update on 7/14, 7/17, and 7/29. However, the record indicated the resident's dressing was not changed as ordered and care planned on 7/20, 7/23, or 7/26.

A Resident Weekly Skin Check Sheet for Resident #1 documented that skin checks were conducted on 7/8, 7/11, 7/14, and 7/21. The following handwritten notes were documented on the weekly skin checks:

*7/8/08 - "Peri[neal] area very red. Open wound on [right] buttock fold. Bandage came off during shower. It needs to be replaced. Will continue to monitor."

* 7/11/08 - "Wound present to [right] gluteal fold also yeast, redness appears in groin [and] on

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| C 789 | Continued From page 10<br>thighs. New Tx's [treatments] started today for both areas."<br><br>* 7/14/08 - "Dressing to [right] gluteal changed. The area has deteriorated. Will cont[inue] to monitor. Also recorded on Daily Pressure Ulcer Sheet. Will cont[inue] to monitor."<br><br>* 7/21/08 - "No new skin issues at this time. Res[ident] cont[inues] to have dressing to [right] gluteal pressure ulcer. No drainage noted. Will cont[inue] to monitor."<br><br>* 7/29/08 - "Dressing to pressure ulcer changed. The wound has deteriorated since I saw it last. No new skin issues at this time."<br><br>August 2008 recapitulated physician orders for Resident #1 documented the EPC cream and Allevyn adhesive dressing were discontinued on 7/5/08 and 7/11/08 respectively. The orders included the following handwritten directive, dated 7/11/08: "Cleanse wound to [right] gluteal fold [with] wound cleanser or N/S [normal saline]. Pat off old Idodosorb [with] gauze (illegible) wound bed sl[ightly] moist. Apply Idodosorb to gauze cut smaller than hydrophilic foam. Place gauze on wound bed. Cover [with] foam. Use skin prep[aration] on edges. Wait till dry. Tape in place. [Change every] 2-3 days [and] PRN."<br><br>Resident #1's August MAR did not document the wound had been cleansed or dressing changed from 8/1/08 - 8/7/08. No other documentation was provided by the facility that indicated the wound had been cleansed or the dressing changed from 8/1/08 through the complaint investigation of 8/6-8/7/08.<br><br>A diagram dated 8/1/08 and provided to | C 789 | | |

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| C 789 | Continued From page 11<br><br>surveyors at the time of investigation included a hand drawn representation of the resident's right gluteal fold pressure ulcer. The diagram included a handwritten note that read, "3 cm circular open area wound is necrotic." The word "necrotic" was underlined. Under "details," was a handwritten note that documented, "The area to her buttock/this was noted on 7/5/08 at that time the area consisted mostly of denuded skin; however, the wound has declined and now as shown above. Referral to wound clinic requested." A second diagram of the wound, also dated 8/1/08, described the wound as "3 cm circular [and] 1.5 [centimeters] at deepest point." The second diagram also included the handwritten word "necrotic" with a drawn arrow pointing to a large area of the depicted wound.<br><br>An IDT Note, dated 8/1/08, documented, "[Resident #1's] wound has declined since this nurse last saw it. (Approx[imately] 2 weeks ago). The wound is 3 cm circular, with a 1 cm denuded area. At its deepest the wound [is] 1.5 cm deep. This accounts for approx 1/4 of the wound area ... The other 3/4 of the wound is approx 1 cm deep, all of the inner aspect of the wound appears 'necrotic.' This nurse advises that this [resident] would be best served with a wound clinic appointment."<br><br>Resident #1 received a referral on 8/1/08 to a local wound clinic, which was also faxed to the clinic on 8/1/08, according to a FAX coversheet provided by the facility. A return FAX from the wound clinic to the facility, dated 8/4/08, directed the facility to, "Please call to sched[ule] [an] appt [appointment]."<br><br>On 8/06/08, at 11:00 am, the resident's right gluteal pressure ulcer was observed by the | C 789 | | |

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| C 789 | Continued From page 12<br><br>surveyor and an LN. The intact dressing was totally covered with brown, dry drainage. The dressing was not dated. The LN indicated there was a foul odor when the dressing was removed. The LN staged the wound as a Stage IV due to eschar. The entire width of the wound was measured by the LN as 8.3 cm, with 4.0 cm covered with eschar, and the length as 5.4 cm. The quarter sized indentation in the center of the eschar was measured as 0.5 cm deep. The area surrounding the wound was not red or edematous. The resident did not complain of pain during the dressing change.<br><br>Immediately after the dressing change, the LN was interviewed. She stated she works on both sides of the building and everytime she has been gone or has worked on the opposite hall and came back to work with the resident the wound was bigger. The resident has had the wound for "many months" stated the LN.<br><br>A Physician Telephone Order, dated 8/6/08, directed staff to apply, "Wet to dry dressing BID to coccyx area. [Physician] to be here in am [morning] to debride area."<br><br>An IDT Note, dated 8/6/08, documented, "[Physician] will visit in the am to debride coccyx area. Continue to monitor for pain."<br><br>An IDT Note, dated 8/7/08, and signed by the resident's physician, documented, "Major concern is MRSA [and right] buttock wound for which she is on her 2nd course of TMP/SMX. Skin: 10 cm X [by] 10 cm Grade II ulcer over [right] buttock [with] tunneling 4 cm deep X 3 cm wide fanning out ... Necrotic tissue that we tried to remove today after irrigation with NSS [normal saline solution]. Grade I ulcer infer[ior] medial to above | C 789 | | |

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| | 135020 | A. BUILDING _____ B. WING _____ | C 08/07/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMMETT REHAB & HEALTHCARE INC | 714 NORTH BUTTE AVENUE EMMETT, ID 83617 |

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| C 789 | Continued From page 13<br>wound. Culture [positive] for E.Coli [Escherichia coli] and MRSA dated 7/2/8. Wound debrided partially and tunneling area filled ... [Right] buttock Grade III ulcer/multistage ulcer with [positive] MRSA and [positive] E.Coli. Wound care clinic referral for 8/13/08."<br><br>On 8/6/08, at 1:25 p.m., and on 8/7/08 at 11:32 a.m., the resident's pressure relief mattress was inspected by surveyors. The pressure relief mattress was set for a resident weighing between 200 and 250-pounds during both observations. According to the facility's weight monitoring records, Resident #1 weighed approximately 169 pounds at the time of investigation. In an interview on 8/7/08, at 12:30 p.m., the DON stated the pressure relief mattress "wasn't set where it should be" to provide maximum pressure relief.<br><br>At the time of the complaint investigation, 8/6-8/7/08, Resident #1 was observed repeatedly in her room. Surveyors did not observe staff practicing contact precautions or any signs in the facility that notified staff or visitors that contact isolation precautions were in effect for Resident #1. Additionally, no staff member during the course of the complaint investigation advised surveyors that the resident was under contact isolation precautions for MRSA.<br><br>On 8/7/08, at 11:30 p.m., the resident's wheelchair cushion was observed by surveyors. The cushion included a pommel in the front center intended to help prevent the resident from sliding forward in the wheelchair, was approximately three-inches thick, and was made of foam with a vinyl cover.<br><br>On 8/7/08, at 12:05 p.m., the facility's physical | C 789 | | |

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| C 789 | Continued From page 14<br>therapist provided surveyors with a copy of a catalog photograph and description of the cushion in Resident #1's wheelchair. The description read, "Designed for slide control and hip abduction ..." According to the catalog description, the cushion was not designed for relieving pressure.<br><br>On 8/7/08, at 1:52 p.m., one of the facility's owners and the physical therapy staff showed surveyors an "interim" wheelchair cushion the owner described as "the best we have in-house." The owner and physical therapy staff informed surveyors the resident's wheelchair cushion would be replaced with the interim cushion until a "state-of-the-art" pressure-relieving cushion arriving later that day could be provided to the resident.<br><br>On 8/7/08, at 12:30 p.m., the facility's Administrator, DON, Corporate Vice President, and owners were interviewed and questioned about the lack of contact isolation precautions to prevent the spread of Resident #1's MRSA to other residents, or signs warning other residents, staff, and visitors of MRSA contact precautions for Resident #1. The DON stated the resident was placed on contact precautions, but "I don't know why it wasn't documented."<br><br>During the 8/7/08 interview, the facility's Administrator, DON, Corporate Vice President, and owners were asked about the 3/17/08 pressure ulcer risk assessment that placed the resident as a "low risk" for skin impairment despite a long history of compromise, limited mobility, risk for friction and shearing from transfers, and bed- or chairbound status. The vice president stated the score was based on history and physical assessment conducted by | C 789 | | |

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| C 789 | Continued From page 15<br>nursing staff at the facility.<br><br>When asked about the MAR that indicated Resident #1 was not given four antibiotic treatments, the vice president and owner stated the resident did receive the ordered dosages of antibiotic treatments. Documentation was provided that indicated no TMP/SMX antibiotic doses were returned to the facility's pharmacy. However, the facility was asked for but did not provide documentation that the four doses of antibiotic treatment were administered.<br><br>During the 8/7/08 interview, the facility provided surveyors with a copy of its Condensed Wound Protocol. Under, Tracking Current Wounds, the facility's protocol documented: "1. Assess and measure wound weekly per schedule. 2. Make a note in chart on wound care record in binder. 3. Evaluate efficacy of current treatment. If not effective after 1-2 weeks (LN judgement) then discuss need for new treatment with LPN, DNS, MD [Medical Director] ... 4. If new treatment ordered, use 3 part form and add to copy and text sheet. 5. Record all on Wound Care Log in binder."<br><br>When asked about the lacking documentation pertaining to wound assessment and measurement, notes on wound care, evaluation of current treatments per commonly accepted standards of practice and the facility's own protocol and Care Plan updates, the vice president stated, "[Resident #1's LN] should have started daily monitoring [and] it's part of the system" to update Care Plans when skin breakdowns occurred.<br><br>Resident #1 was admitted to the facility with a high risk for, and history of, pressure ulcers and | C 789 | | |

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| C 789 | Continued From page 16<br>care planned for skin integrity interventions that did not change over the course of her three year residency at the facility. In 2008, the resident developed an "open area" to the right gluteal fold that progressed to a Stage IV pressure ulcer with necrotic tissue. The facility's own protocols and physician's orders to assess the wound daily and treat according to order were not followed in April 2008 and the Care Plan was not updated to reflect the development of a skin impairment. Weekly skin checks in May 2008 contained no reference to the resident's worsening pressure ulcer, and records documented the wound was not assessed or treated as physician ordered. Also in May 2008, Resident #1's Care Plan was not updated and nursing notes did not include any documentation regarding the wound. In June 2008, the facility failed to assess or treat the wound as ordered, according to its records, and the resident's Care Plan was not updated. Also in June 2008, Resident #1's annual MDS assessment did not identify the presence of a pressure ulcer, but coded the resident as having bruises or abrasions. Dietary changes to assist with skin wound healing were not implemented at any time during the development of the resident's pressure ulcer to the right gluteal fold, the resident's bed was not inflated to a level that would maximize pressure relief to the affected area, the resident's wheelchair cushion was not designed to relieve pressure, and no contact isolation procedures or precautions were put into place to protect against the spread of MRSA to staff or other residents. | C 789 | | |